Section 7

Quality and Appropriateness of Care

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

The KidsCare Program uses performance measures, quality standards, information strategies and quality improvement studies to assure high quality care for members. The tools include:

- Quality standards defined in policy and contract
- Annual on-site operational and financial reviews
- Performance indicator and utilization measurement studies
- Compliance with national quality measures

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. X Quality standards

Each contractor adheres to specific quality/utilization standards established by AHCCCS for the KidsCare Program. A comprehensive plan prepared by the contractor includes the following components:

- Program monitoring
- Program evaluation
- Member education
- Provider education
- Compliance with mandatory components of preventive care visits.

Contractors participate in an annual review of the KidsCare program which includes on-site visits by AHCCCS staff to contractors and medical record audits.

AHCCCS monitors compliance with quality assurance standards through an established process of operational and financial reviews for the Medicaid program. The reviews are conducted by a review team comprised of AHCCCS staff. The reviews are performed on-site through interviews with appropriate personnel and through review of documentation in the following areas:

- Administration and Management
- Provider Services/Network Management
- Grievance and Appeals
- Medical Management

- Quality/Utilization Management
- Dental Services
- Maternal Health/Family Planning
- Behavioral Health
- Delivery System and Access to Care Standards
- Member Services
- Financial

The review tool contains standards from the review areas identified above and provides the basis for assessing contractor performance, as well as identifying areas where improvements can be made or where there are areas of noteworthy performance and accomplishment.

7.1.2. X Performance measurement

AHCCCS requires contractors to meet the AHCCCS performance measures which are defined using HEDIS methodology as a guide. In particular, performance measurement will focus on the following areas:

- Age appropriate childhood immunizations
- Dental visits
- Well child visits in the first 15 months of life
- Well child visits in the third, fourth, fifth, and sixth year of life
- Access to a regular source of primary care

Indicator	Summary Description
1. Childhood Immunization Rate	The percent of members age two who were continuously enrolled for 12 months and received recommended immunizations.
2. Annual Dental Visit	The percent of members age 3-19 with at least one dental visit in the reporting year.
3. Well Child Visits Under 15 Months	The percent of children age 15 months who received all recommended well child visits during the reporting year.
4. Well Child Visits for 3, 4, 5 and 6 Year Olds	The percent of children 3-6 who received a well child visit during the last year.

7.1.3. X Information strategies

All contractors must inform new members about services within ten days of enrollment. Information includes:

- Benefits of preventive care
- A complete description of services available
- How to obtain these services and assistance with scheduling of appointments

- A statement regarding copayments which may be required

In addition, both eligibility workers and contractors are required to educate KidsCare Program enrollees about their benefits, rights and responsibilities. This education focuses on the importance of preventive services, such as immunizations and dental visits, health promotion activities and the importance of regular visits to their primary care provider instead of using the emergency room for primary care.

7.1.4. X Quality improvement strategies

AHCCCS began a Quality Improvement Initiative in 1995 designed to use encounter data to monitor quality and to test new concepts of quality of care based on many of the recommendations for measurement from the Quality Assurance Reform Initiative (QARI) and the National Committee for Quality Assurance. The major components of the Initiative include:

Performance Measures as listed in subsection 7.1.2.

Financial Measures of health plan fiscal viability, management of care, timely payment of claims and documentation of medical expenses.

Member Satisfaction Surveys conducted to provide information on access to care, communication between members and providers, and quality of care.

Provider Satisfaction Surveys designed to assess primary care practitioners' satisfaction with the KidsCare Program.

In the future, the Consumer Assessment of Health Plans Survey (CAHPS) data may be incorporated into AHCCCS' Quality Improvement Initiative, as well as any new reporting requirements which may be developed.

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

Effective October 1, 2001 Kidscare members are eligible for the same services covered for members under the Title XIX program, as specified in the acute-care renewal contract.

The AHCCCS Medical Policy Manual further specifies that KidsCare services must be provided according to community standards and standards under Title XIX for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

enrolled members. This ensures access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.

The AHCCCS Medical Policy Manual also states that, "Contractors must comply with all Quality Management and Quality Improvement requirements." Acute-care contractors are encouraged to include in their EPSDT annual plans and quarterly progress reports activities that will ensure access to services by KidsCare members and/or acknowledge that EPSDT activities apply to both Title XIX and Title XXI members. These reports include monitoring and evaluation of utilization of services.

Members enrolled under the KidsCare Program are included in analysis of the AHCCCS acute-care Performance Indicators for well-child and dental visits. Title XXI members are reported separately for immunizations and children's access to PCPs. The KidsCare population also is included in medical audits, as appropriate.

Additional monitoring is accomplished through the OFR process.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

AHCCCS requires all contractors to have sufficient provider capacity to absorb the additional KidsCare enrollment. Currently, all AHCCCS members have a choice of at least two contractors.

Contractors are required to meet the AHCCCS contractual standards for network capacity for primary care providers (PCPs). These standards include appointment availability, geographic accessibility, quality and utilization. AHCCCSA informs all health plans when a PCP, contracted with more than one contractor, exceeds 1800 AHCCCS members in their panel. This allows the health plans to more closely monitor these PCPs' adherence to the standards. All Contractors have a system in place to monitor and ensure that each member is assigned to an individual PCP and that PCP assignment data is current. Members are allowed to choose their initial PCP from the health plan network and change the assignment should they wish to do so.

In addition, KidsCare enrollees are assured access through existing AHCCCS standards for appointment standards for emergency, urgent and routine care, specialty providers, and dentists.

Contractors provide emergency services facilities adequately staffed by qualified medical professionals to provide emergency care on a 24-hour per day, 7-day per week basis for treatment of medically emergent conditions. Contractors must educate members about the appropriate utilization of emergency room services and monitor utilization by both members and providers.

AHCCCS, through its operational and financial reviews, monitors contractor compliance with these standards. The health plans are also required to submit a description of their networks to the Agency on a quarterly basis.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

Contractors must follow care coordination policies set forth in of the AHCCCS Medical Policy Manual. These requirements include policies and procedures for identifying members with complex, serious and/or at-risk medical conditions, assessing those conditions, identifying medical procedures to address and/or monitor the conditions, ensuring adequate care coordination among providers, and developing a plan of care appropriate to those conditions. The care plan must eliminate barriers to direct access to specialists, provide adequate access to support services, be time-specific, and be updated periodically.

Children with certain chronic, complex, or serious medical conditions receive services related to those conditions through the Children's Rehabilitative Services (CRS) program administered by the Arizona Department of Health Services. Contractors refer members who are potentially eligible for CRS services to the program for evaluation and enrollment if eligible. Contractors are required to monitor referrals to CRS and ensure that CRS-covered services are provided in a timely manner to eligible children. PCPs are required to coordinate care with CRS and to include those services in the member's medical record.

PCPs are accountable for maintaining a medical record which incorporates documentation of all health care services provided to assigned members, including PCP services, specialty medical and/or behavioral health services, all medications prescribed by the PCP and/or other providers, authorized durable medical equipment, dental services, emergency care, and hospitalizations, as required in the AHCCCS Medical Policy Manual. Contractors monitor PCP compliance with medical record keeping requirements through regular chart audits.

Contractors must ensure that appointments standards are met for specialty referrals within the following timeframes: emergency, within 24 hours of referral; urgent, within three days of referral; and routine, within 45 days of referral. Contractors monitor provider compliance with appointment standards through "secret shopper phone calls or regular/periodic on-site visits."

Indian Health Services and 638 Tribal Facilities are responsible for maintaining continuity of care and maintaining a complete medical record for each assigned member, as well as providing necessary referrals for specialty care.

AHCCCS monitors and assesses contractors' care coordination and case management processes, including referral to Children's Rehabilitative Services (CRS) and behavioral health services, through the Operational Financial Reviews (OFRs). Contractor compliance with appointment availability standards and QM/QI requirements also are evaluated in the OFRs.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

The state complies with this requirement of decisions related to the prior authorization of health services. The timeframe for prior authorization of decisions is the same in SCHIP as in the Medicaid program.